



An Implementation Roadmap for State Policymakers Applying
Mental Health and Substance Use Disorder Parity
Requirements to Medicaid and Children's Health Insurance
Programs

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1. Introduction to the Parity Implementation Roadmap

This Parity Implementation Roadmap is designed for Medicaid and Children’s Health Insurance Program (CHIP) officials who are engaged in parity compliance activities. The document outlines the resources and expertise needed to perform the analysis required under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) regulations. It addresses initial preparatory steps for states, issues to consider when performing the analysis, parity deficiencies, and ongoing monitoring. The Appendix contains a mapping tool to determine parity approach depending on the health insurance program type. This Roadmap is intended to be a companion document to the Parity Compliance Toolkit. The Toolkit explains the technical requirements of MHPAEA, whereas the Roadmap presents suggestions for steps states may undertake and the types of organizations and staff that states may engage to implement those requirements.

2. Getting Started: General Parity Requirements and Approach to Determining Parity

Toolkit Section 2.2, titled *Key Steps in the Parity Analysis Process*, provides an outline of major tasks associated with parity compliance: identifying, defining, and classifying benefits; analyzing financial requirements, dollar limits, and quantitative and nonquantitative treatment limitations; ensuring availability of information; implementing changes necessary; and identifying ongoing processes to monitor and track compliance.

Key Considerations for States

States manage and deliver physical and behavioral health benefits within their Medicaid and CHIP plans in different ways, such as using integrated managed care plans, behavioral health carve-outs through Prepaid Inpatient Health Plans (PIHPs) or Prepaid Ambulatory Health Plans (PAHPs), or fee for service (FFS) payments. Some states have hybrid designs, and some show regional variations. Before getting started, state policymakers will want to think about how these state-specific benefit configurations and requirements will affect their parity compliance activities and timelines, who will need to be brought in to assist in the work, what resources can be leveraged, and how to best engage stakeholders. Although all states must be in compliance with parity requirements by October 2, 2017, the timeline for specific tasks within states will vary. For example, states that contract management of all Medicaid and/or CHIP medical and surgical (M/S) and mental health and substance use disorder (MH/SUD) benefits to managed care organizations (MCOs) will have a different set of tasks for compliance than those states that cover some of these benefits through PIHPs, PAHPs, or FFS plans in addition to MCOs. Table 1 provides an outline of initial steps and considerations for state policymakers who are beginning this work.

Table 1. Initial Parity Implementation Tasks and Considerations

Key Task	Considerations
<p>1. Identify the scope of the state’s parity analysis</p>	<ul style="list-style-type: none"> ✓ For Medicaid: <ul style="list-style-type: none"> ○ In states that contract with MCOs for the full range of Medicaid M/S and MH/SUD benefits, MCOs are responsible for the parity analysis. In states that carve out some M/S benefits or MH/SUD benefits (including any LTSS) to a PIHP, PAHP, or FFS system, the state will be responsible for the parity analysis across these various delivery systems. ○ A benefit package includes all benefits provided to a specific population group (e.g., children, adults, individuals within a nursing facility) regardless of how those benefits are delivered (e.g., FFS, MCO, PIHP, PAHP or combination). As a first step, states may want to catalog Medicaid benefit packages and delivery systems to ensure a thorough analysis. This step may be more or less complicated depending, for example, on how many different plans are available and how these plans interact with other systems to provide the full spectrum of Medicaid services. ○ States can come into compliance through a variety of mechanisms, including but not limited to the amendment and submission of managed care contracts to CMS.¹ ✓ For CHIP: <ul style="list-style-type: none"> ○ CHIP plans vary by state, with different configurations depending on whether the program is participating in the title XXI funded Medicaid expansion, a separate program, or a combination of the two programs. In states where CHIP administration is incorporated into the Medicaid agency or the CHIP plan includes a Medicaid expansion, there may be overlap in administrative responsibility for parity. ○ For CHIP plans, a benefit package includes all benefits provided to an eligible population (e.g., children in certain income bands or with specific health conditions), regardless of how those benefits are delivered (e.g., FFS, MCO, PIHP, PAHP, or combination). As a first step, states may want to catalog CHIP benefit packages and delivery systems to ensure a thorough analysis. This step may be more or less complicated depending, for example, on how many different plans are available and how these plans interact with other systems to provide the full spectrum of CHIP services.

¹ Centers for Medicare & Medicaid Services. 81 FR 18389. May 31, 2016. <https://www.federalregister.gov/d/2016-06876/p-367>

Key Task	Considerations
	<ul style="list-style-type: none"> ○ Separate CHIP plans may be deemed compliant with MHPHEA if they provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services that meet the statutory requirements for this program.² CHIP leaders will want to work closely with their Medicaid counterparts to ensure that these requirements are met; states will document compliance through CHIP State Plan Amendments (SPAs). ○ States with separate CHIPs that are not pursuing deemed compliance will need to complete a parity analysis. If the separate CHIP utilizes a managed care delivery system, states will need to work with MCOs to perform the analysis. If services are delivered through FFS or across multiple systems, states will need to perform the parity analysis themselves. ○ States that have a title XXI funded Medicaid expansion CHIP utilizing a managed care delivery system will need to work with MCOs to perform the parity analysis. If services are delivered through FFS or across multiple systems, states will need to perform the parity analysis themselves. ✓ For Alternative Benefit Plans (ABPs): <ul style="list-style-type: none"> ○ Because CMS has reviewed all approved ABPs for parity compliance and states have attested to their compliance with MHPAEA in the ABP SPAs, states with approved ABPs are not required to conduct a new parity analysis. CMS will review new ABP SPA applications as they are submitted to determine whether the ABP complies with the final parity rule.³ ✓ States must post documentation demonstrating compliance on the state website—see Section 4 below titled <i>Demonstration of Parity Compliance</i>. ✓ For additional guidance in determining the state’s scope of work in parity analysis across Medicaid, CHIP, and ABPs, see Appendix A for a parity approach mapping tool.
2. Convene a parity work group	<ul style="list-style-type: none"> ✓ Because the parity analysis will require diverse expertise and perspectives (depending on the state’s scope of work, as discussed above) state policymakers may find it helpful to convene an interdisciplinary and cross-agency committee that includes the following staff competencies:

² EPSDT services are health benefits for children under age 21 that cover comprehensive and preventive health care services. Under section 1905(r) of the Social Security Act, states must provide screening, vision, dental, and hearing services at intervals that align with reasonable standards of medical practice. Additionally, section 1902(a)(43) requires states to inform eligible beneficiaries on the availability of EPSDT services. They also must arrange for the provision of covered screenings and corrective treatments, for example through nonemergency transportation.

³ Centers for Medicare & Medicaid Services. 81 FR 18389, 18410. 2016.

Key Task	Considerations
	<ul style="list-style-type: none"> ○ Understanding of M/S and MH/SUD benefits (including LTSS when applicable) and delivery systems for both types of benefits, to ensure comprehensive identification and review of benefit packages ○ If applicable, understanding of the separate CHIP’s provision of the EPSDT benefit and whether the state should propose deemed compliance to CMS through a SPA that documents compliance with MHPAEA ○ Benefits management expertise to inform identification and analysis of financial requirements, as well as quantitative and nonquantitative limitations, including knowledge of medical necessity and reasons for claims denial disclosure⁴ policies and practices ○ Data and reporting expertise to support claims-based, encounter, and other data analyses needed for the parity analysis ○ Access to actuarial expertise, as needed ○ Managed care contracting and operations, as applicable, to coordinate with the managed care plans, develop parity-compliant contract language, and inform compliance planning and monitoring ○ Medicaid and CHIP compliance and audit expertise. ✓ State policymakers also may find it helpful to convene external experts and stakeholders who have a technical understanding of parity requirements, either as part of the work group or separately, to promote a full understanding of parity compliance and anticipated impact. External partners may include managed care plan representatives to ensure strong communication and problem-solving capabilities from the outset, advocacy organizations to inform and reinforce oversight and monitoring processes, and additional subject matter experts based on state-specific issues and challenges. ✓ States will have different oversight mechanisms for parity—some states will use their attorney general office, whereas other states may have specific administrative or regulatory oversight committees or agencies. It will be helpful to engage with these staff early on in the process.
3. Align state-specific timelines	<ul style="list-style-type: none"> ✓ Identify legislative timelines in anticipation of state plan, managed care capitation rate, or other budget-sensitive changes that may need to be made. Determine whether a briefing to a legislative oversight committee will be required. ✓ Identify regulatory timeframes in order to make necessary changes to benefits, including public notices and stakeholder participation.

⁴ Beneficiaries must have access to medical necessity criteria in accordance with 42 CFR § 438.915(a) for managed care, § 440.395 for ABPs, and § 457.496 for CHIP.

Key Task	Considerations
	<ul style="list-style-type: none"> ✓ Identify MCO, PIHP, PAHP and other contracting deadlines in anticipation of changes required to meet regulatory renewal standards. ✓ Review any state parity laws or regulations for alignment and/or preemption issues.
4. Consider existing resources for additional technical support	<ul style="list-style-type: none"> ✓ Leverage existing state expertise from commercial plan parity analysis. State health insurance commissioners, attorney general’s offices, and the state bar’s health law membership may have materials, templates, processes or guidelines developed in preparation for MHPAEA’s application to commercial plans that can inform the state’s approach.
5. Engage stakeholders	<ul style="list-style-type: none"> ✓ Establish mechanisms to provide public education on parity timelines and expectations through bulletins, policy guides, discussions with key stakeholders, and the opportunity for public comment. ✓ Federally recognized tribes and other indian tribes and organizations in the state (such as regional indian health boards, urban indian health organizations, nonfederally recognized tribes, and units of the indian Health Service) are to be consulted prior to submitting a SPA or waiver to CMS, in accordance with the state’s approved tribal consultation policy.⁵ ✓ Communicate early and often with state professional associations to work through particular problem areas, test strategies, and disseminate parity compliance information to members. ✓ States may want to leverage existing stakeholder committees, such as the medical care advisory committees required in state Medicaid plans, in the parity implementation and compliance processes.⁶

Abbreviations: CHIP, Children’s Health Insurance Program; FFS, fee for service; LTSS, long-term services and supports; MH/SUD, mental health and substance use disorder; M/S, medical and surgical; MCO, managed care organization; MHPHEA, Mental Health Parity and Addiction Equity Act; PAHP, Prepaid Ambulatory Health Plan; PIHP, Prepaid Inpatient Health Plan; SPA, State Plan Amendment.

3. Conducting the Parity Analysis

In states that contract with MCOs for all Medicaid benefits (for instance, a carved-in plan that includes all M/S and MH/SUD services in the state plan), the MCOs are responsible for performing the parity analysis. Once the parity analysis is completed, the state remains responsible for defining benefits, participating in classification and mapping, and posting compliance documentation on its website.⁷ In contrast, in states with multiple delivery systems

⁵ See section 5006(e) of the American Recovery and Reinvestment Act (ARRA) and State Medicaid Director (SMD) Letter, #10-001.

⁶ 42 CFR § 431.12. Medical Care Advisory Committee. October 1, 2011. <https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol4/CFR-2011-title42-vol4-sec431-12>

⁷ 42 CFR § 438.920(b). State responsibilities.

(for instance, MH/SUD services that are delivered via FFS or a specialty behavioral health plan), the state will need to conduct the parity analysis. For separate CHIPs using MCOs to provide all benefits, the state has the flexibility to conduct the analysis or allow the MCO to conduct it. Similar to Medicaid, the state must complete the parity analysis if it uses a combination of delivery systems.

3.1 Defining Mental Health and Substance Use Disorder (MH/SUD) Benefits

States will need to identify a generally recognized independent standard of current medical practice for defining MH/SUD and M/S benefits. Work group members from state behavioral health agencies can be important sources of information on clinical and diagnostic frameworks currently used for mental health and substance use disorders, as well as on different diagnostic tools used for adult and child populations. See Toolkit Section 3.3, titled *Standards Identified in the Final Regulation to Identify MH/SUD and M/S Conditions*.

Key Considerations for Defining Benefits

- **Include Long-Term Services and Supports.** The final regulations clarify that LTSS are covered under MHPAEA. States may want to engage home and community-based services (HCBS) state staff and providers to assist in defining these services. HCBS waivers contain relevant definitions and diagnostic categories that can be helpful in indicating how the state previously has defined intermediate and long-term services.
- **Review “in lieu of” and optional services.** Services delivered in lieu of covered benefits, or on an optional basis, also are subject to MHPAEA requirements.
- **Create consistency.** All states are required to differentiate MH/SUD benefits from M/S benefits. States will benefit from providing standardized definitions of these benefits so that (1) all contracted MCOs understand the scope of their analytical obligations and (2) beneficiaries, who may switch plans, have access to a consistent set of MH/SUD benefits.

3.2 Mapping Benefits to Classifications

Financial requirements and treatment limitations apply by benefit classification. To conduct the parity analysis, all M/S and MH/SUD benefits must be mapped to four classifications of benefits: inpatient, outpatient, prescription drugs, or emergency care. Guidance on establishing the four classifications can be found in Toolkit Section 4, titled *Mapping Benefits to Classifications*.

Key Considerations for Classifying Benefits

- **Understand the full service array.** In states with a combination of delivery systems, policymakers will need to ensure that they capture the full breadth of services, whether those services are provided through a combination of plans, FFS, or state-administered systems. A complete picture of benefits may come from a variety of sources, including plan administrators, and may include the following:
 - State plans and amendments
 - Waivers and demonstrations

- Managed care contracts
- Provider policy manuals
- Medical necessity definitions
- Member handbooks.
- **Leverage work group membership.** The state work group should have subject matter expertise that can pull together different pieces of the benefit puzzle and provide insight into how they work together. State managed care staff, MH/SUD state agency leadership, state staff familiar with claims and encounters, and member services personnel all can be helpful in describing the various delivery systems and their interactions.
- **Standardize classifications within benefit packages and across plans.** As with the definition of benefits, states will need to decide how items and services that are covered within each benefit package fall into each of the four classifications. States that contract Medicaid and/or CHIP benefits to MCOs will want to standardize how benefits are classified across plans in order to facilitate oversight and to create consistency for beneficiaries who switch plans.

3.3 Claims-Based Analysis for Parity Compliance

States and/or managed care plans must evaluate: (1) financial requirements, (2) quantitative treatment limitations (QTLs), and (3) aggregate lifetime and annual dollar limits on MH/SUD benefits to make sure that they are no more restrictive than those that apply to substantially all M/S benefits in the same classification. The Toolkit Section 5 titled *Claims-Based Analysis for Parity Compliance* provides information on how the claims-based analysis works for the three types of limits. It offers guidance on how to identify limitations that require testing and on what information to collect to assess compliance. For a list of questions states should keep in mind while conducting the claims-based analyses, see Toolkit Section 5.1, titled *Introduction*.

Key Considerations for Conducting the Claims-Based Analysis

- **Identify which requirements and limitations require testing.** States that do not have financial requirements, QTLs, or dollar limits for MH/SUD benefits—or states that elect to eliminate them—will not need to complete the claims-based data analysis. If managed care plans do not apply the financial requirements, QTLs, or dollar limits specified in the state plan, the state will need to document that the limits are not applied.
- **Develop the necessary data sets.** States with multiple delivery systems may need to compare benefits across both managed care and FFS systems, so coordinating across both claims and encounter data could be necessary. The state Medicaid Management Information System (MMIS) fiscal agent may be a helpful resource for developing data sets that can be used to perform the claims-based analysis; MCOs will provide encounter data.
- **Consider convening a time-limited data subgroup to prepare and align data for the parity analysis.** Different data sets (e.g., Medicaid claims data, encounter data from multiple managed care plans) can complicate the parity analysis. State staff and point

people from managed care plans may find it helpful to convene as a subgroup in order to develop standards for data queries and data sets. These standards can facilitate clear comparisons across delivery systems and across multiple plans.

- **Standardize the data task.** States that oversaw compliance of MHPAEA in private plans noted that standardizing processes—including the development of guidance, tools, and forms for insurers to assist in the parity analysis—made oversight and compliance an easier task from the state’s perspective.⁸

3.4 Identifying and Analyzing Nonquantitative Treatment Limitations

The Medicaid and CHIP parity rules prohibit states, MCOs, PIHPs, or PAHPs from imposing a nonquantitative treatment limitation (NQTL), as written and in operation, on MH/SUD benefits in any classification unless it is comparably applied to M/S benefits in the classification. Specifically, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits must be comparable to and applied no more stringently than those used in applying the NQTL to M/S benefits. A detailed discussion of the NQTL analysis is available in Toolkit Section 6.1, titled *What is an NQTL?*

Key Considerations for Identifying and Analyzing NQTLs

- **Think broadly when identifying NQTLs.** For NQTL analysis, review factors including but not limited to the following:
 - The use of utilization review strategies (e.g., prior authorization, concurrent and retrospective review, prior notification requirements)
 - Prescription drug formularies
 - Criteria for medical necessity (e.g., limiting treatments that are considered “experimental”)
 - Step therapy or fail first policies
 - Probability of improvement requirements
 - Written treatment plan requirements
 - Network design (e.g., standards for coverage of out-of-network providers, reimbursement, network participation criteria)
 - Provider participation criteria (e.g., exclusion of services provided by clinical social workers)
 - Blanket exclusion of services for court-ordered or involuntary treatment when the care otherwise would be considered medically necessary.

The Departments of Labor, Health and Human Services, and the Treasury have issued subregulatory guidance in the form of frequently asked questions (FAQs, referred to in

⁸ Substance Abuse and Mental Health Services Administration. Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States. Rockville, MD: U.S. Department of Health and Human Services; 2016. <http://store.samhsa.gov/shin/content/SMA16-4983/SMA16-4983.pdf>

this document as the tri-Department FAQs) that provide additional examples of types of NQTLs.^{9,10}

In addition to subject matter experts on the parity internal and external work group, the following types of experts may be helpful: (1) pharmacy benefits managers and Pharmacy and Therapeutics Committee representatives who understand parity in formularies, (2) utilization review and other organizations that may govern selection and application of medical necessity criteria, (3) and professional provider organizations for provider admission and credentialing requirements. These resources can provide information on operations, processes, strategies, evidentiary standards, or other factors used in determining how various NQTLs are applied in writing and in practice. States may want to disseminate examples of NQTL violations and warning signs described in the tri-Departments FAQs (referenced above) to these organizations.

- **Review medical necessity criteria as applied to MH/SUD and M/S services.** Medicaid programs may contract with benefit administrators to apply medical necessity criteria to MH/SUD services. The parity analysis requires a review of whether the processes, strategies, evidentiary standards, and other factors being used for MH/SUD medical necessity determinations are comparable to and no more stringent than those being used for M/S determinations.
- **Review plan-specific language on NQTLs.** Because NQTLs are embedded within plan operations, keep in mind that the operations and associated NQTLs for each combination of M/S and MH/SUD vendors that deliver a benefit package must be evaluated under parity.
- **Consider standardization of key terms and data collection approaches.** States that are performing the parity analysis themselves, and states where the MCOs perform this analysis, may find it helpful to develop templates, checklists, and other tools that promote a standard understanding of NQTLs across plans and systems. These tools should be made readily available to carriers, for example through the state Medicaid agency website.¹¹
- **Review credentialing standards and their impact on network adequacy.** Network adequacy may emerge as a compliance challenge if plans are using more restrictive processes, strategies, standards, or other factors for including MH/SUD providers in their networks compared with M/S providers. The Medicaid and CHIP managed care final rule published on May 6, 2016, requires states to establish network adequacy standards in Medicaid and CHIP managed care for certain types of providers, including MH/SUD

⁹ ACA FAQs Part VII Q2–Q6, Issued 11/17/2011; FAQs on Implementation of MHPAEA Q6, Issued 5/9/2012; ACA FAQs Part 34 Q4–Q9, Issued 10/27/2016; ACA FAQs Part 31 Q11, Issued 4/20/2016.

¹⁰ Department of Labor. Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance. <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

¹¹ Ibid.

providers.¹² States also may be able to leverage requirements for annual network adequacy certification to track indicators related to parity.

3.5 Availability of Information Requirements

As explained in Toolkit Section 8, titled *Availability of Information*, the Medicaid/CHIP parity rule includes two requirements regarding availability of information related to MH/SUD benefits. The first is that the criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries, potential beneficiaries, and providers upon request. The second is that the reason for any denial of reimbursement or payment for MH/SUD benefits must be made available to beneficiaries. A number of tri-Department FAQs related to the disclosure requirements have been issued that may be helpful for states to review and disseminate.¹³

Key Considerations

- **Standardize the approach.** In ensuring that the criteria for medical necessity are available to beneficiaries, states can work with MCOs, PIHPs, and PAHPs to adopt a standard approach to ensure that beneficiaries have access to medical necessity criteria in accordance with federal law.¹⁴ This could be accomplished, for example, by posting the information to a readily accessible website. The form of disclosure also should be standardized with a uniform disclosure that is consistent for M/S and MH/SUD. Availability of information requirements also apply to separate CHIPs, in accordance with 42 CFR 457.496(e), that do not achieve deemed compliance with MHPAEA. States should consider whether consistency in terms of disclosures across both Medicaid and CHIP would be beneficial for implementing parity. Best practices to increase transparency include clearly labeling medical necessity documents, creating the ability to search for these documents on the plan's homepage, and providing a telephone number for individuals to call to request more detailed medical necessity criteria.¹⁵
- **Review denial of payment procedures.** The state should ensure that when the state or plan denies coverage for a MH/SUD benefit to a beneficiary,¹⁶ the reason for that denial includes the applicable medical necessity criteria as applied to that beneficiary and/or any other reasons for that specific denial. Again, states may want to standardize the format for these denial notices, to ensure that all payers and plans engaged in the delivery of MH/SUD services are providing all beneficiaries with the same level of detail.

¹² Centers for Medicare & Medicaid Services. Medicaid and CHIP Managed Care Final Rule. May 6, 2016. <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>

¹³ ACA FAQs Part V Q9–Q10, Issued 12/22/2010; ACA FAQs Part XVII Q8–Q9, Issued 11/8/2013; ACA FAQs Part XXIX Q12–Q13, Issued 10/23/2015; ACA FAQs Part 31 Q9–Q10, Issued 4/20/2016; ACA FAQs Part 34 Q2, Issued 10/27/2016.

¹⁴ Availability of information requirements for both medical necessity determination criteria and reasons for any denial can be found in 42 CFR § 438.915(a) for managed care, § 440.395 for ABPs, and § 457.496 for CHIP. Managed care and CHIP plans can be deemed compliant with the requirements for disclosure of criteria for medical necessity determinations by disseminating practice guidelines in accordance with 42 CFR § 438.236.

¹⁵ Submitted by Truven Health Analytics to Substance Abuse and Mental Health Services Administration. Medical Necessity Criteria in Commercial Health Plans: Current and Best Practices Final Report. September 28, 2015.

¹⁶ 42 CFR §§ 438.404, 438.915, 440.395, 457.496; 42 CFR §§ 438.236, 457.110, 457.1130 (CHIP-specific).

4. Demonstration of Parity Compliance

States will need to document their findings from the parity analysis, highlighting any necessary follow-up activities and compiling them into a parity compliance plan. As a part of the plan to address any identified gaps in coverage, states have a number of (nonexclusive) options to become parity-compliant:

- 1) Amend state plan(s) and/or state regulation(s) if necessary to ensure that the service package complies with MHPAEA final rules regarding Medicaid, CHIP, and ABPs. States should be cognizant of the federal regulatory requirements that mandate public notice to affected stakeholders of any significant change in state standards for setting payment rates for services.¹⁷
- 2) Amend plan contracts with MCOs, PIHPs, and/or PAHPs to add services to the benefit package and/or eliminate limits and/or requirements on benefits determined not to be in compliance with parity requirements. Services not included in the state plan may need to be incorporated into actuarially sound, updated capitation rates.

Once the state has taken steps to become parity-compliant, the state must provide documentation of compliance to the general public by posting this information to its Medicaid website by October 2, 2017.¹⁸

Key Considerations for Demonstrating Parity Compliance

- **Anticipate any legislative action or budget review needed for compliance.** Factor in the state-specific process for amending the state plan, which may include legislative oversight.
- **Review managed care contracts for submission to CMS.** Once contracts are amended, states will submit the contracts to CMS in order to demonstrate compliance with parity. MCO contracts typically are submitted on an annual basis, and they should include materials demonstrating that the state has verified the parity analysis. States may consider including provisions in their managed care contracts to report on the outcome of the parity analysis to ensure that parity is achieved and can be overseen appropriately.
- **Consider whether deemed compliance is a viable option for the separate CHIP.** All separate CHIPs will need to submit a SPA to document compliance with parity, with an effective date no later than October 2, 2017. Depending on the configuration of programs across state health agencies, state policymakers may want to confer with Medicaid EPSDT experts.

States whose separate CHIP coverage provides statutorily complete EPSDT can choose to pursue deemed compliance with MHPAEA. States pursuing deemed compliance should ensure that relevant managed care contract language is clear, calling out the

¹⁷ 42 CFR § 447.205. Public notice of changes in statewide methods and standards for setting payment rates. Nov. 2, 2015.

¹⁸ 42 CFR § 438.920(b). State responsibilities.

federal statutory components, if applicable; these states also should include in the state CHIP plan a description of how it complies with the applicable Medicaid statutes and regulations regarding EPSDT.¹⁹

If the application of EPSDT in the separate CHIP is not in accordance with sections 1902(a)(43) and 1905(r) of the Act, the state may consider the following:

1. What benefits need to be changed to meet deemed compliance requirements?
2. Does making the needed changes comport with state goals for children's coverage?
3. Does aligning benefit changes in CHIP with the provision of EPSDT in Medicaid result in more efficient systems?
4. How would implementing the needed changes affect the state's process, timeline, and budget?

For states not pursuing deemed compliance, and/or for title XXI-funded Medicaid expansion CHIPs where the deemed status option is not available, the state must conduct a full benefit and cost-sharing analysis of the CHIP state plan to determine compliance with general parity rules. This analysis will be documented using a SPA template.

5. Ongoing Compliance and Monitoring Activities

Once a state has demonstrated and posted documentation of compliance by October 2, 2017, the state will need to develop and implement monitoring procedures, including a process for ongoing parity reassessment.

Key Considerations for Ongoing Compliance

- **Use oversight and plan assessment tools to document parity.** States may want to leverage existing oversight and plan assessment tools to monitor parity compliance, including managed care plan reporting requirements, network adequacy and access requirements, Healthcare Effectiveness Data and Information Set (HEDIS) submissions, and consumer complaint processes. State oversight of MHPAEA implementation in commercial plans found that it is useful to review consumer complaints, compliance surveys, market conduct examinations, and/or network adequacy assessments in this review to identify potential areas of noncompliance.²⁰ State enforcement agencies, such as attorneys general, also have used disproportionately higher denial rates for MH/SUD claims as flags necessitating a fuller investigation into parity violations.²¹

¹⁹ 42 CFR §§ 438.900, 440.395, and 457.496.

²⁰ Substance Abuse and Mental Health Services Administration. Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States. Rockville, MD: U.S. Department of Health and Human Services; 2016. <http://store.samhsa.gov/shin/content/SMA16-4983/SMA16-4983.pdf>

²¹ Parity Implementation Coalition. State Snapshot on Parity Implementation: New York. June 2015. <https://www.thenationalcouncil.org/wp-content/uploads/2015/08/New-York-State-Snapshot-on-Parity-Implementation.pdf>

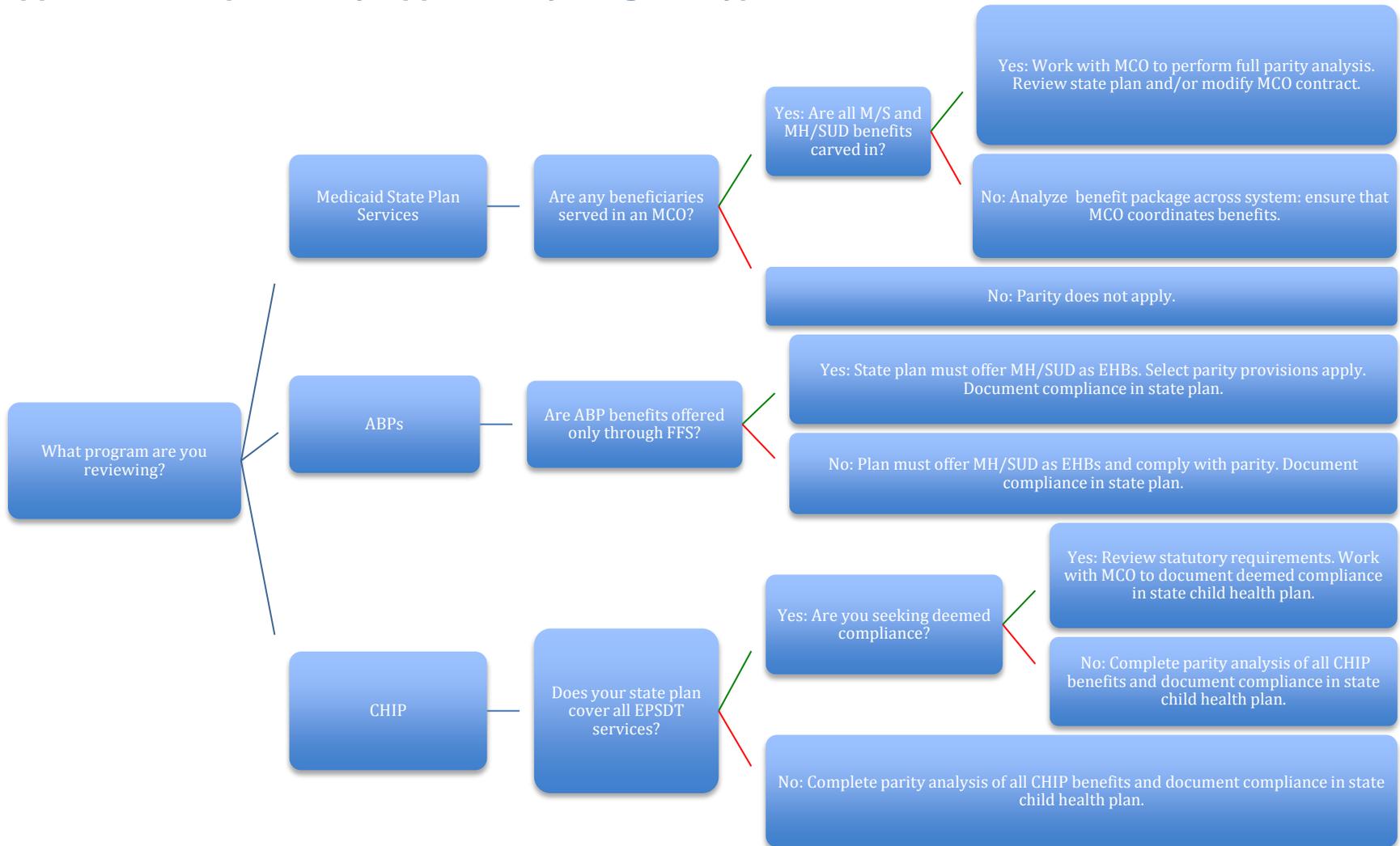
- Establish regular opportunities for parity review, monitoring, and reporting. Regular opportunities for review of parity compliance include contract renewals for managed care plans and amendments to the state plans for Medicaid, CHIP, and ABPs. Other events, such as significant changes to provider networks, also may trigger review of parity compliance. States must update the parity compliance information on their Medicaid websites prior to making any changes in MCO, PIHP, PAHP, or FFS state plan benefits²²; this may present an opportunity for states to build scheduled reviews into their ongoing monitoring.
- **Establish communication pathways for interested parties.** The state can provide compliance and monitoring updates through bulletins, policy guides, discussions with key stakeholders, and the opportunity for public comment. These updates should include findings and/or relevant data, which can assist in communicating the state's overall pathway to achieving and maintaining parity.

6. Conclusion

The final rules on MHPAEA provide states with the framework to ensure that Medicaid, CHIP, and ABPs offer parity-compliant benefits. Compliance with MHPAEA final regulations will offer state policymakers an important tool for improving access to MH/SUD services and for eliminating disparities in treatment of individuals in need of MH/SUD treatment. States can use this Parity Implementation Roadmap in tandem with the Parity Compliance Toolkit to identify the operational and technical components of their work.

²² 42 CFR § 438.920(b). State responsibilities.

Appendix A: Map of Parity Approach by Program Type



Abbreviations: ABP, Alternative Benefit Plan; CHIP, Children’s Health Insurance Program; EHB, essential health benefit; EPSDT, Early and Periodic Screening, Diagnostic and Treatment; M/S, medical and surgical; MCO, managed care organization; MH/SUD, mental health and substance use disorder.